
Program Memorandum Intermediaries

Department of Health and
Human Services (DHHS)
HEALTH CARE FINANCING
ADMINISTRATION (HCFA)

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CHANGE REQUEST 1664

SUBJECT: Calculating Payment-to-Cost Ratios (PCR) for Purposes of Determining Transitional Corridor Payments Under the Outpatient Prospective Payment System (OPPS) and Revising the Criteria Under Which a Provider May Request a Recalculation of Its Cost-to-Charge Ratio

This Program Memorandum (PM) provides instructions to intermediaries for calculating the (PCRs) required by PM A-01-44. The PCR is needed to determine transitional corridor payment. This PM also adds two additional criteria under which a provider may request a recalculation of its cost-to-charge ratio.

Background - Payment-to-Cost Ratios

Under regulations at 42 CFR 419.70, hospitals and community mental health centers (CMHCs) that are subject to the OPPS may be eligible to receive a transitional corridor payment, frequently referred to as a transitional outpatient payment (TOP). The purpose of the TOP is to restore some of the decrease in payment that a provider may experience under the OPPS. Providers that are eligible for TOPs receive monthly interim payments as described in PM A-00-36. However, the final TOP amount is calculated based on the provider's settled cost report. Final TOP payments for a calendar year are based on the difference between what the provider was paid under the OPPS and the provider's "pre-Balanced Budget Act (BBA) amount". The pre-BBA amount is an estimate of what the provider would have been paid during the calendar year for the same services under the system that was in effect prior to OPPS. If the pre-BBA amount exceeds the actual OPPS payments a provider received during a calendar year, rural hospitals with 100 or fewer beds, qualifying cancer centers, and children's hospitals will receive the entire amount of the difference between their OPPS payments and their pre-BBA amount. All other hospitals and CMHCs will receive a portion of the difference as a TOP.

The pre-BBA amount is calculated by multiplying the provider's PCR, based on the provider's base year cost report, times the reasonable costs the provider incurred during a calendar year to furnish the services that were paid under the OPPS. For most hospitals and CMHCs, the base year cost report used to calculate the PCR is the cost report that ended during calendar year 1996. However, if a hospital or CMHC did not file a cost report that ended in calendar year 1996, the PCR will be calculated using the provider's first cost report that ended after calendar year 1996 and before calendar year 2001.

The hospital cost report form was substantially revised effective for cost reporting periods that ended on or after September 30, 1996. Hospital cost reports for periods ending prior to September 30, 1996 were filed using Form HCFA-2552-92, while cost reports for periods ending on or after September 30, 1996 were filed using Form HCFA-2552-96. Consequently, this PM describes two separate calculations of PCRs, one for hospital cost reporting periods ending on or after January 1, 1996, and before September 30, 1996. The other one is for cost reporting periods ending on or after September 30, 1996, and before January 1, 2001.

Note that a provider's base year costs, used as the denominator in calculating a PCR, does not take into account the 5.8 percent reduction for operating costs and the 10 percent reduction in capital costs that were in effect during the base year. That is, the cost is the provider's cost for the cost reporting period without those reductions. For further clarification of this issue, please see the interim final rule published in the *Federal Register* on November 13, 2000. (65 SFR 67814 – 67815)

Clarifications

In the case of mergers, acquisitions and other such changes the PCR for the surviving provider number should be used. If less than a full year is reflected in the provider's cost report for a base year, use the next full year cost report that ended prior to January 1, 2001 instead.

PCRs for CMHCs

Under the system in effect prior to OPPS, unlike hospitals that, as a result of capital and operating cost reductions, blended payment methods, etc., received payments that were less than costs, CMHC payments were based on the full amount of their reasonable costs. For this reason, the PCR for any CMHC base year cost report is 1.0. That is, the Medicare payments to a CMHC prior to OPPS were equal to the reasonable costs the CMHC incurred to treat Medicare patients. CMHCs must have filed a cost report that ended on or after January 1, 1996, and before January 1, 2001, to qualify for TOPs, however, a calculation of a provider-specific PCR for CMHC is not necessary, all CMHCs will have a PCR of 1.0.

Calculating a PCR for Hospital Cost Report Periods Ending On or After January 1, 1996, and Before September 30, 1996

Step 1 -- Determining Payments: Calculate payment amounts from the cost report for each type of service as described in A through E, then determine total payments as described in F:

- A. Calculate Payment for Ambulatory Surgical Center Procedures. (Use Worksheet E, Part C.) Payment is the lesser of:
 1. Line 6;
 2. Line 9; or
 3. $(0.58 \times \text{line 1 of Worksheet E, Part C}) + (0.42 \times \text{lesser of line 6 or line 9 of Worksheet E, Part C})$.

- B. Calculate Payment for Radiology Services Subject to the Blended Payment Methodology. (Use Worksheet E, Part D.) Payment is the lesser of:
 1. Line 6;
 2. Line 9; or
 3. $(0.58 \times \text{line 2 of Worksheet E, Part D}) + (0.42 \times \text{lesser of line 6 or line 9 of Worksheet E, Part D})$.

- C. Calculate Payment for Other Diagnostic Services Subject to the Blended Payment Methodology. (Use Worksheet E, Part E.) Payment is the lesser of:
 1. Line 6;
 2. Line 9; or
 3. $(0.50 \times \text{line 2 of Worksheet E, Part E}) + (0.50 \times \text{lesser of line 6 or line 9 of Worksheet E, Part E})$.

- D. Calculate Payment for All Other Services. (Use Worksheet D, Part V, column 9.) Payment is the sum of the amounts for these lines and any subscripts of these lines:
 1. Lines 37 through 49;
 2. Lines 53 through 62;
 3. Line 63, excluding any costs that are not attributable to OPPS services, e.g., costs of FQHCs, RHCs, etc., and
 4. Line 68, excluding any costs not attributable to OPPS services.

- E. Calculate Payment for Vaccines
Payment is the amount on Worksheet D, Part VI, line 3

F. Calculate Total Payments by:

1. Adding amounts determined for A through E in Step 1, above;
2. Subtracting the amount from Worksheet D, Part V, line 102, column 9 (CRNA costs); and
3. The net amount is the payment for the cost reporting period that will be used in calculating the provider's PCR.

Step 2 -- Determining Costs: Determine costs for cost centers and individual services following A through C, then calculate total costs as described in D.

A. Multiply the cost-to-charge ratio (or other statistical ratio in the case of a provider that was an all-inclusive rate provider during the base year) for a cost center from Worksheet C, Part I, column 7, times the charges for that cost center on Worksheet D Part V, columns 2, 3, 4 and 5 to determine outpatient costs for the following lines (i.e., cost centers) and any subscripts of these lines:

1. Lines 37 – 49;
2. Lines 53 – 62;
3. Line 63, excluding any costs that are not attributable to OPSS services, e.g., costs of Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and
4. Line 68, excluding any costs not attributable to OPSS services.

NOTE: For providers apportioning costs to Medicare on other than a charge basis, e.g., all inclusive rate providers: Multiply the unit cost for each department calculated on Worksheet C, Part I, column 7 times the equivalent Medicare units reported on Worksheet D, Part V, columns 2,3, 4, and 5 for the following lines and any subscripts of these lines:

1. Lines 37 – 49;
2. Lines 53 – 62;
3. Line 63, excluding any costs that are not attributable to OPSS services, e.g., costs of FQHCs, RHCs, and
4. Line 68, excluding any costs not attributable to OPSS services.

B. Determine the costs for all departments by adding the cost calculated for all lines in step A.

C. Determine the costs of vaccines by taking the amount from Worksheet D Part VI, line 3.

D. Calculate total payments by:

1. Adding the costs determined in B and C in Step 2, above; and
2. Subtracting the cost from Worksheet D, Part V, line 102, column 9 (CRNA costs).

The net amount is the cost for the cost reporting period that will be used in calculating the provider's PCR.

Step 3 -- Calculate the PCR: Calculate the provider's PCR by dividing the total payments calculated in Step I. F. by the total costs calculated in Step 2. D.

Calculating a PCR for Cost Report Periods Ending On or After September 30, 1996 and Before January 1, 2001

Step 1 -- Determining Payments: Calculate payment amounts from the cost report for each type of service as described in A through E, then determine total payments as described in F:

A. Calculate Payment for Ambulatory Surgical Center Procedures. (Use Worksheet E, Part C.)

Payment is the lesser of:

1. Line 6;
2. Line 7; or
3. $(0.58 \times \text{line 1 of Worksheet E, Part C}) + (0.42 \times \text{lesser of line 6 or line 7 of Worksheet E, Part C})$.

B. Calculate Payment for Radiology Services Subject to the Blended Payment Methodology. (Use Worksheet E, Part D.) Payment is the lesser of:

1. Line 6;
2. Line 7; or
3. $(0.58 \times \text{line 2 of Worksheet E, Part D}) + (0.42 \times \text{lesser of line 6 or line 7 of Worksheet E, Part D})$.

C. Calculate Payment for Other Diagnostic Services Subject to the Blended Payment Methodology. (Use Worksheet E, Part E.) Payment is the lesser of:

1. Line 6;
2. Line 7; or
3. $(0.50 \times \text{line 2 of Worksheet E, Part E}) + (0.50 \times \text{lesser of line 6 or line 7 of Worksheet E, Part E})$.

D. Calculate Payment for All Other Services. (Use Worksheet D, Part V, column 9.) Payment is the sum of the following lines and all subscripts of these lines:

1. Lines 37 through 49;
2. Lines 53 through 62;
3. Line 63, excluding any amounts that are not attributable to OPPS services, e.g. costs of FQHCs, RHCs, and
4. Line 68, excluding any costs not attributable to OPPS services.

E. Calculate Payment for Vaccines.
Payment is the amount on Worksheet D, Part VI, line 3.

F. Calculate Total Payments by:

1. Adding amounts determined for Step 1, A through E, above
2. Subtracting the amount from Worksheet D, Part V, line 102, column 9 (CRNA costs); and
3. The net amount is the total payment for the cost reporting period that will be used in calculating the provider's PCR.

Step 2 -- Determining Costs: Determine costs for cost centers and individual services as described in A through C, then calculate total costs as described in D.

A. Multiply the cost-to-charge ratio (or other statistical ratio in the case of a provider that was an all-inclusive rate provider during the base year) for a cost center from Worksheet C, Part I, column 9, times the charges for that cost center on Worksheet D, Part V, columns 2, 3, 4 and 5 to determine outpatient costs for the following lines (i.e., cost centers) and all subscripts of these lines:

1. Lines 37 – 49;
2. Lines 53 – 62;
3. Line 63, excluding any charges on line 63 which are not attributable to OPPS services, e.g., FQHC services, RHC services), and
4. Line 68, excluding any charges that are not attributable to OPPS services.

NOTE: For providers apportioning costs to Medicare on other than a charge basis, e.g., all inclusive rate providers, multiply the unit cost for each department calculated on Worksheet C, Part I, column 9, times the equivalent Medicare units reported on Worksheet D, Part V, columns 2,3, 4 and 5 for the following lines and all subscripts of these lines:

1. Lines 37 – 49;
 2. Lines 53 – 62;
 3. Line 63, excluding any costs that are not attributable to OPPS services, e.g., costs of FQHCs, RHCs, etc., and
 4. Line 68, excluding any costs not attributable to OPPS services.
- B. Determine the costs for all departments by adding the cost calculated for all lines in step A.
- C. Determine the costs of vaccines by taking the amount from Worksheet D, Part VI, line 3.
- D. Calculate total payments by:
1. Adding the costs determined in B and C in Step 2, above, and
 2. Subtracting the cost from Worksheet D, Part V, line 102, column 9 (CRNA costs).

The net amount is the cost for the cost reporting period that will be used in calculating the provider's PCR.

Step 3 -- Calculate the PCR: Calculate the provider's PCR by dividing the total payments calculated in Step 1. F. by the total costs calculated in Step 2. D.

Timing of PCR Calculations

Intermediary workload may require the prioritization of PCR calculations. Providers that calculate their PCR, following the calculations described above, and submit a copy of their calculation to their intermediary for review and final approval are to be given priority. PCRs must be determined for these providers and lump sum payments (as described below) made not later than 60 days after receipt of the provider's calculation. Calculations of PCRs for all providers who have not submitted a calculation, but who are subject to the OPPS must be completed not later than October 1, 2001.

Using the Newly Calculated PCR for Determining Final TOP Amounts

Final TOP amounts are determined for each calendar year, based on the calendar year or portion of a calendar year that falls within a provider's cost reporting period. The PCR is one factor used on Worksheet E, Part B, of the hospital cost report (Form HCFA-2552 - 96), and Worksheet J-3 of the CMHC cost report (Form HCFA- 2088) in calculating the provider's final TOP amount. Once calculated, the provider's PCR will be used to calculate the provider's pre-BBA amount for all calendar years for which the provider may be eligible for a TOP payment. The PCR will not change each year.

Using the Newly Calculated PCR for Determining Interim TOPs

Providers that are eligible for TOPs receive monthly interim payments as described in PM A-00-36. The calculation of the monthly payment outlined in PM-00-36, under the section Transitional Corridor Payments, uses a national uniform PCR of 80 percent for all providers in step 1. Once you calculate a provider-specific PCR, that PCR will be used in calculating, as per PM A-01-44, monthly interim payments to the provider. The standard systems maintainers will add a PCR field to the Provider Specific File to reflect the provider-specific PCR. Once you calculate a PCR for a provider, enter the PCR into the PCR field on the Provider Specific File. (The standard systems maintainers will revise the monthly TOPS calculation to use the provider-specific PCR, taken from the Provider Specific File by July 1, 2001, as required in PM A-01-44.) Once the standard system TOPS calculation is revised to accept a provider-specific PCR (no later than July 1, 2001), the

provider-specific PCR must be used as soon as it is available. Until a provider-specific PCR is available, on or before October 1, 2001, the monthly TOPs calculation will continue to use the national uniform PCR of 0.8.

Lump Sum Payments

Providers may be eligible for a lump sum payment. The amount of the lump sum payment is the difference between the payments received by the provider calculated using a payment-to-cost ratio of 0.8 and the payments the provider would have received using the payment-to-cost ratio calculated by the intermediary for services provided between the implementation of OPPS on August 1, 2000, and June 30, 2001.

If a provider has an extended repayment plan in effect and the provider is making timely payments, the lump sum payment should be made under the above instruction. However, if there is an overpayment outstanding without a repayment plan in place or the provider has defaulted on an extended repayment plan, the lump sum payment should be reduced or withheld. This assumes that payment is being made to the provider; issue no payment if the provider is under 100 percent suspension or recoupment as defined in §405.371 of Title 42 Code of Federal Regulations. If, for example, the overpayment is \$50,000 and there is no extended repayment plan in place and the proposed lump sum payment is \$100,000, pay \$50,000. In the same example, if the overpayment is \$200,000, make no payment but reduce the indebtedness by \$100,000.

NOTE: It is important to distinguish between excess payments and overpayments in applying this instruction. When an intermediary believes it has paid a provider more than it believes will ultimately be owed to it, the difference is an excess payment. An overpayment exists only when a full examination of claims and payments reveals that there is a specific overpayment owed to the government and the provider has been given a notice to this effect. The above instruction applies to providers with overpayments.

A hospital and its intermediary may have an agreement for the FI to withhold current payments in order to repay a recent overpayment. In this case, the 100 percent offset that may result is not the type of offset or recoupment described in 42 CFR 405.371 because the hospital has voluntarily agreed to repay any overpayments. Hospitals in this situation should receive the lump sum payment. FIs should first apply the payment to the debt or installment that may be due or overdue in accordance with the agreed repayment arrangement to the extent the debt still exists at the time of the payment of the lump sum. It should then issue the balance, if any, to the hospital. You should count the entire amount of the lump sum as a payment for purposes of cost report settlement and inform the hospital that part of or all of its payment has been applied to reduce or eliminate the recent debt.

The lump sum payments supplement what intermediaries are already paying hospitals. Hospitals which receive (or are credited) these additional payments must add them to their cost reports. Hospitals must include the full amount of the lump sum payment on the cost report even if some or all of it was applied to reduce or recover overpayments, as described in the above examples. Intermediaries that process cost reports must be sure that the tentative settlements of the cost reports reflect the proper payments, and that any resulting overpayment should be recovered at settlement according to normal cost reporting settlement procedures.

You should make payment to providers in accordance with this direction within 60 days of receipt of the provider's calculation for those providers who submit a calculation. For all other providers eligible for a lump sum payment, you should make payments no later than October 1, 2001.

Change in Criteria for Considering Requests to Recalculate a Provider's Cost-to-Charge Ratio (CCR)

In PM A-00-63, we described how we calculated provider CCRs used in determining outliers, interim TOP amounts, and device pass-through payments under the OPPS. That PM also set forth certain criteria under which a provider could request that its fiscal intermediary review and recalculate its CCR. This PM adds additional criteria under which a provider may request a CCR

recalculation. In addition to the criteria listed in PM A-00-63, a provider may also request that the intermediary recalculate its CCR in the following cases:

1. Our calculation of CCRs did not include the subscribed cost centers. Therefore, a provider may request a recalculation if it used subscribed cost centers, on the cost report that we used to calculate its CCR, to such an extent that the CCR we calculated is inaccurate; and
2. A provider may request a recalculation of its CCR if the provider made a change in its product line (i.e., the types of services it furnishes) after the cost reporting period that we used to calculate its CCR.

PM A-00-63 indicates which cost reporting period HCFA used in calculating each hospital's CCR.

The *effective date* for this PM is May 13, 2001.

The *implementation date* for this PM is June 15, 2001.

These instructions should be implemented within your current operating budget.

This PM may be discarded after March 31, 2002.

If you have any questions concerning :

The PCR calculation, contact : Janet Wellham (410) 786-4510.

Lump sum payments, contact: Valerie Barton (410) 786-2803.

FI responsibilities to incorporate the PCRs into interim TOPs, contact : Stuart Barranco (410) 786-6152